KC PHYSICIAN PARTNERS Inc

Rheumatology, Allergy & Immunology, Neurology

Ann Warner, MD • Kent Kwas Huston, MD • Michael W. Smith, MD
Kalista Engelman, DO • Christopher Koenig, MD • Julian Magadan, MD • Tina Shah, MD
Jeremy Sharp, MD • Jennifer Kendall, MD • Sarah Fantus, MD • Erica Campbell, DO
Zachary Jacobs, MD • Neha Patel, MD • Travis Sifers, MD • Jaclyn Gill, PA-C • Erica Lathon, APRN-BC • Rola Mahmoud, MD

# AUTHORIZATION TO RELEASE OR REQUEST PROTECTED HEALTH INFORMATION

**Patient Information**

Name of Patient: _____

Date of Birth: _____ MRN: _____

Date of Request: _____ Phone: _____

Address: _____

_____

I authorize Kansas City Physician Partners, Inc. to (circle one) **RELEASE / REQUEST** information from my health records to/from:

***(If for personal use, write "Self" for Organization name.)***

Organization Name: _____

Address: _____

Contact Person: _____

Phone/Fax: _____

Dates of Treatment: _____ to _____

Specific reports to be released/requested:

- ❑ Chart Notes
- ❑ Summary of Care
- ❑ Telephone summaries
- ❑ Laboratory Reports
- ❑ Radiology Reports
- ❑ Radiology images

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- ❑ Entire Health Records
  (including, but not limited to, information regarding medical/health treatment, insurance, demographics, referral documents, and records from other facilities.)

- ❑ Other (Specify): _____

I give specific authorization to release/request the following information:

- ❑ HIV test results
- ❑ Drug and alcohol abuse treatment records
- ❑ Documentation of AIDS diagnosis
- ❑ Psychiatric/Mental Health treatment records

I understand that I may withdraw or revoke my permission at any time. If I withdraw my permission, my information may no longer be released or requested for the reasons covered by this authorization. However, any releases or requests already made with my permission are unable to be taken back. I may revoke this authorization by notifying Kansas City Physician Partners, Inc. in writing. I understand that Kansas City Physician Partners, Inc. utilizes a third-party vendor, ScanSTAT, for all internal medical records requests and releases. These requests may take up to 48 hours to be completed.

My treatment will not be based on the completion of this authorization form. The information to be released by this authorization may be re-released by the person or organization that receives it and may no longer be protected by Federal privacy regulations.

If not revoked earlier, this authorization expires at 11:59 p.m. on the date of_____. If no date is specified, this authorization expires one year from the date it was signed.

I release the individual or organization named in this authorization from legal responsibility or liability for the disclosure of the records as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. I will be provided a copy of this signed authorization, if requested. A photocopy of this authorization is as valid as the original.

Patient/Representative Name: _____ DOB: _____

Patient/Representative Signature: _____ Date: _____